U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 05 April 2005

CASE NO. 2004-BLA-5059

In the Matter of

LORENZA D. BALDWIN,
Claimant

v.

KANAWHA COAL COMPANY,
Employer

and

DIRECTOR, OFFICE OF WORKERS COMPENSATION PROGRAMS,
Party-in-Interest

APPEARANCES:

Roger D. Forman, Esquire
For the Claimant

David L. Yaussy, Esquire
For the Employer

Before: RICHARD A. MORGAN
Administrative Law Judge

DECISION AND ORDER ON MODIFICATION-AWARDING BENEFITS

This proceeding arises from a claim for benefits filed by Lorenza D. Baldwin, a former coal miner, under the Black Lung Benefits Act, 30 U.S.C. §901, *et seq*. Regulations implementing the Act have been published by the Secretary of Labor in Title 20 of the Code of Federal Regulations.[1]

[1] The Secretary of Labor adopted amendments to the "Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969" as set forth in Federal Register/Vol. 65, No. 245 Wednesday, December 20, 2000. The revised Part 718 regulations became effective on January 19, 2001. Since the claim was filed on June 27, 2001 (DX 2), the new regulations are applicable (DX 31).

Black lung benefits are awarded to coal miners who are totally disabled by pneumoconiosis caused by inhalation of harmful dust in the course of coal mine employment and to the surviving dependents of coal miners whose death was caused by pneumoconiosis. Coal workers' pneumoconiosis is commonly known as black lung disease.

A formal hearing was held before the undersigned on December 1, 2004 in Charleston, West Virginia. At that time, all parties were afforded full opportunity to present evidence and argument as provided in the Act and the regulations issued thereunder. Furthermore, the record was initially held open until January 21, 2005 for the submission of Dr. Cohen's post-hearing deposition and closing arguments (TR 56-57, 67-68). The transcript of Dr. Cohen's deposition, dated January 14, 2005, which was submitted under cover letter, dated January 20, 2005, has been marked and received as Claimant's Exhibit 8 (CX 8). Pursuant to my Order Granting Extension of Time, dated January 21, 2005, the due date for the filing of closing arguments was extended to February 4, 2005.

The record consists of the hearing transcript, Director's Exhibits 1 through 31 (DX 1-31); Claimant's Exhibits 1 through 8 (CX 1-8); and Employer's Exhibits 2 through 12 (EX 2-12). However, Employer's Exhibit 1 was excluded as cumulative (TR 32). Furthermore, parts of Employer's Exhibits 10 and 12 have been redacted and/or excluded because they exceed the regulatory limitations for the submission of evidence set forth in the applicable regulations (EX 10, 12; TR 31, 49-52). I have also received and considered the parties' pre-hearing statements and closing arguments.

The findings of fact and conclusions of law which follow are based upon my analysis of the entire record, including all documentary evidence admitted, testimony presented, and arguments made. Where pertinent, I have made credibility determinations concerning the evidence.

Procedural History

The procedural history and findings, as set forth in the "Order Denying Objections to Modification Hearing and Order Rescheduling Hearing," dated September 24, 2004, are incorporated by reference herein.

In summary, Claimant, Lorenza D. Baldwin, filed the current application for black lung benefits under the Act on June 27, 2001 (DX 2). On August 28, 2001, the District Director issued a Notice of Claim by certified mail, which was received on September 10, 2001, in accordance with §725.407 of the new regulations (DX 12). By letter, dated October 4, 2001, the Employer's claims administrator, Accordia Employers Service, responded with a general controversion, pursuant to §725.408 (DX 13).

Pursuant to §725.410, the District Director issued a Schedule for the Submission of Additional Evidence, dated June 4, 2002 (DX 14). By letter, dated June 12, 2002, Employer's counsel filed a timely response thereto, in which he stated that the "employer disagrees with the

Department's preliminary [finding] of claimant's entitlement to benefits and reserves its right to have the claimant examined at a future time." (DX 15).

On May 9, 2003, the District Director issued a Proposed Decision and Order, in accordance with §725.418, in which Claimant was awarded benefits. Furthermore, the parties were notified that "[t]his Order becomes final and effective thirty (30) days from the date printed on this Proof of Service, unless a party to the claim submits a timely request for revision or hearing before an Administrative Law Judge." (DX 19).

The case file contains an unsigned letter, dated May 13, 2003, which was allegedly sent by Employer's counsel to the District Director requesting a formal hearing. However, the May 13, 2003 letter was not received by the District Director until June 21, 2003, when it was received together with a second letter, dated June 19, 2003, in which Employer also requested a formal hearing (DX 22). In the interim, the District Director sent correspondence to Employer, dated June 13, 2003, advising Employer's of its responsibility to pay benefits to Claimant (DX 20). Accordingly, Employer failed to properly file a response to the proposed decision and order within the 30-day period provided under §725.419(a).

On July 1, 2003, Employer filed a timely Motion for Reconsideration with the District Director under §725.310 (DX 24). On July 8, 2003, the District Director summarily denied Employer's modification request based upon the finality of the Proposed Decision and Order, without reconsidering the case on its merits (DX 25).

Following various procedural delays, I held an initial hearing on August 5, 2004 and issued the above-referred Order, dated September 24, 2004. The crux of my ruling therein is that the regulations and case law cited by Claimant and/or the Director are not applicable, since they pertain to §725.413(b)(3) of the *pre*-amendment regulations. In contrast, this case involves the application of §725.419 of the revised regulations, which states in pertinent part:

> (d) If no response to a proposed decision and order is sent to the district director within the period described in paragraph (a) of this section…the proposed decision and order shall become a final decision and order, which is effective upon the expiration of the applicable 30-day period. Once a proposed decision and order…becomes final and effective, all rights to further proceedings with respect to the claim shall be considered waived, *except as provided in §725.310*.

20 C.F.R. §725.419(d) (Emphasis added).

Section 725.310(a) states:

> Upon his or her own initiative, or upon the request of any party on the grounds of a change in conditions or because of a mistake in a determination of fact, the district director may, at any time before one year from the date of the last payment of benefits, or at any time before one year after the denial of a claim, reconsider the terms of an award or denial of benefits.

20 C.F.R. §725.310.

In summary, although Employer failed to file a timely response to the proposed decision and order, as provided in §725.419(a), it filed a timely request for modification under §725.310. *See also* 20 C.F.R. §725.419(d). Accordingly, as set forth in the Order, dated September 24, 2004, the parties have been provided an opportunity to develop and submit evidence for my consideration of the claim on its merits, pursuant to §725.310.[2] As previously stated, a hearing was held before the undersigned on December 1, 2004, and the record was held open until February 4, 2005 for the submission of briefs.

Issues

I. Whether the miner has pneumoconiosis as defined by the Act and the regulations?
II. Whether the miner's pneumoconiosis arose out of coal mine employment?
III. Whether the miner is totally disabled?
IV. Whether the miner's disability is due to pneumoconiosis?
V. Whether the evidence establishes a change in conditions and/or that a mistake was made in a determination of fact under 20 C.F.R. §725.310.

(DX 29; TR 7).

Findings of Fact and Conclusions of Law

Background

A. Coal Miner and Length of Coal Mine Employment

On his application for benefits form, Claimant stated that he engaged in coal mine employment for 34 years, ending on September 1, 1987, when the mine shut down and he retired (DX 2). At the formal hearing held on December 1, 2004, Claimant testified that he worked in the mines "around 36" years, and that he was "pretty sure" that he last worked in September 1988 (TR 59). The documentary evidence, including Claimant's Employment History form (DX 3), the statement by Employer's personnel manager (DX 4), and the Social Security records (DX 5), clearly establish that Claimant's last coal mine employment ended in 1987. Although the Employment History form and Social Security records establish that Claimant engaged in coal mine employment throughout most of the period from 1954 to 1987, the District Director found that, based upon his earnings, Claimant established "25" and/or "25.74" years of coal mine employment (DX 14). Furthermore, in his Proposed Decision and Order awarding benefits, dated May 9, 2003, the District Director stated that Claimant was employed as a coal miner for 25 years from 1954 to September 1, 1987 (DX 19). The Form CM-1025 transmittal sheet indicates that Employer did not contest Claimant's claim of 34 years (DX 29). However, assuming *arguendo* that this issue is contested, I would still find that Claimant has established *at*

[2] Since Employer's response to the proposed decision and order was untimely the award was "final," albeit subject to modification. *See* 20 C.F.R. §725.419(d). Accordingly, if benefits were terminated herein, no payment made prior to the date upon which Employer requested reconsideration under §725.310(a) would be subject to collection or offset. *See* 20 C.F.R. §725.310(d).

least 25 years of coal mine employment during the period beginning in 1954 and ending on September 1, 1987 (DX 2, 3, 4, 5). Moreover, I find that any discrepancy in the exact number of years of coal mine employment in excess of 25 years is inconsequential for the purpose of rendering a decision herein.

B. Timeliness of Filing

Claimant filed his application for benefits under the Act on June 27, 2001 (DX 2). There is a rebuttable presumption that every claim for benefits is timely filed. 20 C.F.R. §725.308(c). Furthermore, the timeliness of this filing is not contested (DX 29).

C. Responsible Operator

Employer, Kanawha Coal Company, is the properly designated responsible operator in this case, under Subpart G, Part 725 of the Regulations (DX 2, 3, 4, 5; TR 59).

D. Dependents

Claimant had no dependents for the purpose of augmentation of benefits under the Act (DX 2; TR 64).

E. Personal, Employment, and Smoking History

Claimant, Lorenza D. Baldwin, was born on October 1, 1933; thus, he is 71 years old (DX 2; TR 58). At the formal hearing held on December 1, 2004, Claimant was walking around with oxygen. He testified that he started taking oxygen in December 2003 (TR 58). As stated above, I find that Claimant retired on September 1, 1987, when the mine closed down (DX 2, 3, 4). His last usual coal mine job was as a continuous miner operator (DX 3, 4; TR 59). Although Claimant had a helper, he still had trouble performing his coal mine job when he left the mines. Claimant also stated that he worked in very dust conditions. Claimant testified that, if the coal mines had not close, he probably could have continued to work for awhile, but not much longer (TR 59-60). In fact, Claimant tried to find additional work when Employer's coal mine closed, but there were no other jobs available in other mines (TR 65).

Clamant testified that Dr. Nellhaus has treated him for breathing problems, and saw him when he was hospitalized in December 2003 with heart problems. Claimant stated that he has had two stents put in. Dr. Nellhaus was the physician who put him on oxygen (TR 62-63).

Claimant acknowledged that he also has some kind of bone disease which involves a deterioration of his ribs. However, he did not know the medical term for the disease. In addition, Claimant testified that he has been told that he has emphysema. On the other hand, Claimant stated that he had not been told that he suffers from asthma (TR 64-65).

Claimant provided somewhat confusing statements regarding his cigarette smoking history. On the one hand, Claimant estimated that he smoked "maybe 20 years," because he wasn't allowed to smoke in the mines (TR 61). On the other hand, Claimant said he "might have

been 30 years old" when he began smoking, and that he quit in December 2003, when he as placed on oxygen (*i.e.,* when he was 70 years old) (TR 61). Claimant denied that he used to smoke a full pack per day, as reported by Dr. Zaldivar. Claimant stated that, although he might have smoked one or two cigarettes more per day, he averaged about ½ pack daily, and probably not even that much (TR 62).

As discussed below, the examining physicians also provided somewhat ambiguous cigarette smoking histories. For example, on August 30, 2001, Dr. Gaziano reported that Claimant is "currently smoking," and that he started smoking at age 25. When asked "how much," Dr. Gaziano noted: "1/2 pack per day 1 pk day." (DX 7, Sec. C3). However, on January 23, 2002, Dr. Zaldivar issued a History & Physical Examination report, in which he stated, in pertinent part: "He says he began smoking in his 30's. He used to smoke a pack of cigarettes per day, but now he smokes ½ pack. He did this about 3 years ago." (DX 10). On the other hand, the pulmonary function study report, dated January 23, 2002, sets forth the following smoking history: "SMOKES CIGARETTES 30Y 0.5P/DAY 15 PACK/YRS" (DX 10). Taken as a whole, I find that Claimant smoked an average of approximately ½ to ¾ per day for 40 years ending in December 2003.

Medical Evidence

The medical evidence consists of various x-ray interpretations, pulmonary function studies, arterial blood gases, and physicians' opinions (including CT scan interpretations), as discussed below.

A. Chest X-rays

The record contains interpretations of chest x-rays, dated August 30, 2001 (DX 7, 8; EX 3, 4) and January 23, 2002 (DX 10; CX 2, 4), respectively.

Of the foregoing, three are positive for simple pneumoconiosis; namely, Dr. Gaziano's (1/1) interpretation of the August 31, 2001 x-ray (DX 7), Dr. Aycoth's (3/2) reading of the January 23, 2002 film (CX 2), and Dr. Cappiello's (2/2) interpretation of the January 23, 2002 x-ray (CX 4). Furthermore, I note that Dr. Gaziano and Dr. Aycoth reported film quality "1" on the respective x-rays. However, Dr. Cappiello reported film quality "3" on the latter x-ray, and noted "underexposure" (CX 4).

On the other hand, Dr. Shipley interpreted the visible portions of the August 30, 2001 x-ray as negative for pneumoconiosis, while noting that a significant amount of lung parenchyma is obscured. Furthermore, Dr. Shipley reported the film quality as "3" and noted the film is "light" (EX 4). Dr. Binns interpreted the August 30, 2001 x-ray for film quality only, and reported quality "2," while also noting the film is "light" (DX 8). However, Dr. Wiot reviewed the August 30, 2001 film, and reported that it is "unreadable by ILO standards" (EX 3). In addition, Dr. Zaldivar reported that the January 23, 2002 film is "unreadable for pneumoconiosis" (DX 10).

My consideration of the record is not simply based upon the number of positive and negative interpretations, but rather the qualifications of the physicians. All of the above-listed physicians are B-readers. Furthermore, Drs. Aycoth, Cappiello, Shipley, Binns, and Wiot are dual-qualified B-readers and Board-certified radiologists.

In summary, I find that the August 30, 2001 x-ray is inconclusive. Although Dr. Gaziano, a B-reader, interpreted the film as positive for pneumoconiosis, Dr. Shipley, a dual-qualified B-reader and Board-certified radiologist, provided a negative interpretation of the visible portions of the same film. Moreover, while Dr. Binns noted quality "2," Dr. Wiot found that the August 30, 2001 film is unreadable. Since there is a dispute among dual-qualified B-readers and Board-certified radiologists as to whether the August 30, 2001 x-ray is even readable for pneumoconiosis, I accord it little weight. On the other hand, I find that the January 23, 2002 films is positive for pneumoconiosis. Although Dr. Zaldivar found that the January 23, 2002 film is unreadable, he is *not* a Board-certified radiologist. On the other hand, despite some disparity between Drs. Aycoth and Cappiello regarding the film quality and the severity of pneumoconiosis shown, both physicians found the January 23, 2002 film is readable and interpreted the film as positive for simple pneumoconiosis. Moreover, as stated above, Drs. Aycoth and Cappiello are both dual-qualified B-readers and Board-certified radiologists. In view of the foregoing, I find that Claimant has met his burden of establishing the presence of pneumoconiosis by a preponderance of the x-ray evidence.

B. Pulmonary Function Studies

A claimant must show he is totally disabled and that his total pulmonary disability is caused by pneumoconiosis. The regulations set forth criteria to be used to determine the existence of total disability which include the results of pulmonary function studies and arterial blood gas studies.

The record contains pulmonary function studies, dated August 30, 2001 (DX 7) and January 23, 2002 (DX 10), respectively. The former was only conducted before bronchodilator and the latter was administered before and after bronchodilator. All of the pulmonary function studies (before and after bronchodilator) are qualifying under the criteria stated in 20 C.F.R. Part 718, Appendix B. Therefore, the pulmonary function studies establish the presence of a total (pulmonary or respiratory) disability.

C. Arterial Blood Gas Studies

Blood gas studies are performed to detect an impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise.

The record includes arterial blood gas studies which were administered on August 30, 2001 (DX 7) and January 23, 2002 (DX 10), respectively. These arterial blood gas studies were only administered at rest. Both of the resting blood gases are qualifying under the regulatory standards set forth in 20 C.F.R. Part 718, Appendix C. Therefore, the arterial blood gas studies also establish a finding of total disability.

D. Physicians' Opinions (including CT Scan Interpretations)

The record contains various interpretations of a CT scan, dated July 2, 2001 (DX 9; EX 2, 12; CX 3, 5).

Dr. Wiot, a B-reader and Board-certified radiologist (EX 5), reported no evidence of coal worker's pneumoconiosis on the above-referred CT scan. On the other hand, Dr. Wiot found "marked distortion of the chest wall with multiple ribs most consistent with fibrous dysplasis," but noted that this "is not a manifestation of coal dust exposure." In addition, Dr. Wiot found "over-expansion of the lungs, consistent with emphysema." (DX 9).

Dr. Harold B. Spitz, a B-reader and Board-certified radiologist (EX 5), also found no evidence of coal worker's pneumoconiosis. However, Dr. Spitz also reported "possible emphysema" and "chest wall deformity, which may be on the basis on (sic) fibrous dysplasia." (EX 2).

Dr. Stephen Elksnis, who apparently is a radiologist for Associated Radiologists, Inc., in Charleston, West Virginia (EX 8), but whose credentials are not otherwise in evidence, interpreted the same CT scan as follows:

> IMPRESSION:
>
> There are multiple large expansile rib lesions with a chondral matrix compatible with a diagnosis of a chondrosarcoma. This would be a multi-focal neoplasm. I have no previous studies available for comparison.
>
> High resolution CT scan of the chest:
>
> High resolution images were obtained for occupational exposure. Diffuse patchy emphysematous changes with increased interstitial markings within the lungs. There is no nodularity noted. There is no evidence for discrete infiltrate. Expansile calcified rib lesions are noted bilaterally compatible with diagnosis of chondrosarcoma.

(EX 12). Furthermore, Dr. Elksnis issued a cursory, supplemental report, dated June 14, 2004, in which he stated:

> I have reviewed the CT scan of the chest of Lorenza D. Baldwin. The exam was performed and interpreted on 2 July 2001.
>
> I am unable to make the diagnosis of occupational pneumoconiosis based on the CT scan of the chest.

(EX 8).

Dr. Edward Aycoth, a B-reader and Board-certified radiologist (CX 6), interpreted the CT scan, dated July 2, 2001, as positive for pneumoconiosis category 3/2, q/t. In addition, Dr. Aycoth found "bilateral chest wall masses appearing to be expansile rib lesions" and "chronic obstructive pulmonary disease (em)" (CX 3).

Dr. Enrico Cappiello, a B-reader and Board-certified radiologist (CX 7), interpreted the same CT scan as positive for pneumoconiosis category p/s, 2/2. Furthermore, Dr. Cappiello also reported "bilateral chest wall masses appearing to be expansile rib lesions" and "chronic obstructive pulmonary disease (em)." (CX 5).

In addition to the above-listed interpretations of the CT scan, dated July 2, 2001, there are references to the CT scan in some of the medical reports, as discussed below. For example, Dr. Nellhaus' report, dated June 9, 2004, notes that the CT scan shows "no nodularity that would be consistent with coalworkers (sic) pneumoconiosis," but that there is evidence of diffuse emphysema and chondrosarcoma (EX 7). Furthermore, Dr. Zaldivar's report, dated April 15, 2002, states, in pertinent part: "In this instance, according to the CT scan of 07/02/2001, there was no evidence of any reaction of the lungs to any inhaled dust." (DX 10). In addition, Dr. Zaldivar's reports, dated May 24, 2004 (EX 6) and July 7, 2004 (EX 9) also refer to the CT scan. I note, however, that it is unclear whether Drs. Nellhaus and/or Zaldivar personally interpreted the CT scan, or whether they were simply relying on the interpretations of other physicians. Furthermore, even assuming that Dr. Nellhaus and/or Dr. Zaldivar interpreted the CT scan, their findings would be accorded less weight because they lack the radiological credentials of Drs. Wiot, Spitz, Aycoth, and Cappiello. The record indicates that Dr. Nellhaus practices "Pulmonary-Critical Care Medicine" and has no known radiological credentials (EX 7). Moreover, although Dr. Zaldivar is a B-reader, he is not a Board-certified radiologist (DX 10).

Although the majority of the CT scan interpretations are negative for pneumoconiosis, I find that the interpretations by dual-qualified B-readers and Board-certified radiologists should be accorded greater weight, in view of their superior radiological credentials. As outlined above, the CT scan interpretations by dual-qualified B-readers and Board-certified radiologists are conflicting regarding the presence or absence of pneumoconiosis. Accordingly, I find that the CT scan evidence neither precludes nor establishes the existence of pneumoconiosis.

The case file also includes the medical notes, reports and/or deposition testimony of Drs. Nellhaus (EX 11, 7), Gaziano (DX 7), Zaldivar (DX 10; EX 6, 9), Altmeyer (EX 10), and Cohen (CX 1,8).

Dr. Kurt M. Nellhaus, who treated Claimant for breathing problems (TR 63), examined Claimant on June 15, 2001 (EX 11). Dr. Nellhaus' medical notes on that date indicate that Claimant's chief complaint is "COPD," and that he was being evaluated for dyspnea. Claimant's past medical history includes COPD, chondro-sarcoma, and CAD. The last intervention with a stent was reportedly in 1999. As of June 15, 2001, Dr. Nellhaus reported that Claimant "still smokes about ½ pack of cigarettes daily;" that he worked 34 years in the coal mines; but was denied black lung. On physical examination of the lungs, Dr. Nellhaus noted "diminished breath sounds bilaterally." Chest x-ray showed "marked calcification of the chest wall mainly along the lateral chest wall margins." However, Dr. Nellhaus also noted: "Not much can be said about the

lung parenchyma because of the obscuring overlap with the chest wall lesions." Accordingly, Dr. Nellhaus planned to have a CT of the chest to more fully characterize the parenchymal abnormalities. Under "IMPRESSION," Dr. Nellhaus also reported "COPD." (EX 11).

In a supplemental report, dated July 9, 2004, Dr. Nellhaus stated:

> Mr. Baldwin, as you know, is a 70-year-old man who (sic) I saw in June 2001 for evaluation of dyspnea. His history is significant for coal mining, chronic obstructive pulmonary disease and coronary artery disease. He worked in coal mines for 34 years. Also notable is his history of chondrosarcoma of the chest.
>
> On 7/2/01 a high resolution CT scan of the chest was performed to rule out occupational exposure. No nodularity that would be consistent with coalworkers (sic) pneumoconiosis was seen. There was diffuse emphysema. Of course, there was radiographic evidence of chondrosarcoma.
>
> While we know that coal dust can contribute to COPD, it would be difficult to assess the relative contributions of cigarette smoking and coal dust to his COPD. There are (sic) no objective data to make a diagnosis of coal workers pneumoconiosis.

(EX 7).

Dominic J. Gaziano, a B-reader who is Board-certified in Internal Medicine and Chest Disease, examined Claimant on August 30, 2001 (DX 7). On a U.S. Department of Labor form, Dr. Gaziano reported Claimant a 36-year coal mine employment history, and listed his last usual coal mine job of at least one year as "continuous miner operator." As previously stated, Dr. Gaziano reported an ongoing cigarette smoking history which began at age 25. He stated that the job entailed "much heavy lifting, spikes, shoveling. All heavy work and some very heavy manual labor." In summary, Dr. Gaziano set forth Claimant's family and medical histories, and subjective complaints of sputum, wheezing, dyspnea, cough, orthopnea, and paroxysmal nocturnal dyspnea. Dr. Gaziano also noted various abnormalities on inspection and auscultation of the thorax and lung. Furthermore, Dr. Gaziano discussed various clinical test results, which were conducted on August 30, 2001, in the "Summary of Results" section of the form report, as follows:

Chest X-ray:	CWP 1/1
Vent Study (PFS)	severe impairment
Arterial Blood Gas	moderate impairment

(DX 7, Sec. D5).

Under the Cardiopulmonary Diagnoses section of the U.S. Department of Labor form report, Dr. Gaziano reported that Claimant suffers from "coal workers pneumoconiosis" and "chronic obstructive pulmonary disease." (DX 7, Sec. D6). Dr. Gaziano attributed the diagnosed conditions to "coal mining and cigarette smoking" (DX 7, Sec. D7). When asked the severity of Claimant's impairment from a chronic respiratory or pulmonary disease, if any, Dr. Gaziano

stated: "Severe impairment. Unable to do any work in mines." (DX 7, Sec. D8a). Finally, Dr. Gaziano stated that both of the above-listed diagnosed conditions contributed to a "moderate" degree to the impairment (DX 7, Sec. D8b).

Dr. George L. Zaldivar is a B-reader, who is Board-certified in Internal Medicine, Pulmonary Diseases, Sleep Disorder, and Critical Care Medicine (DX 10). Dr. Zaldivar examined Claimant on January 23, 2002. In a "History & Physical Examination" report on that date, Dr. Zaldivar set forth Claimant's chief complaint of "shortness of breath," and also noted that Claimant said he has "some sort of congenital bone disease, as well." Dr. Zaldivar also set forth a history of present illness which includes shortness of breath beginning in 1973, and chest pains before a stent was put in. He also set forth Claimant's past medical history, which included the smoking history which I previously cited above. In addition, Dr. Zaldivar set forth a 36-year coal mine employment history ending in 1988, when the mine closed down. Furthermore, he reported Claimant's last usual coal mine job as a continuous miner operator. Moreover, Dr. Zaldivar also reported Claimant's personal and social history; family and personal illnesses; and, review of systems. Dr. Zaldivar also set forth his findings on physical examination. In pertinent part, Dr. Zaldivar stated: "Lungs are clear to auscultation without wheezes, crackles, or rales." In summary, Dr. Zaldivar stated:

IMPRESSION:

1. Congenital bone disorder, which has obscured the lung parenchyma by x-ray and appears to be encroaching inside the chest cavity.
2. Shortness of breath.
3. No abnormal breath sounds.
4. History of smoking.
5. History of heart disease.

(DX 10).

In a supplemental report, dated April 15, 2002 (DX 10), Dr. Zaldivar reviewed and analyzed his own examination, including laboratory data which he obtained, and, he also reviewed other available medical evidence. In summary, Dr. Zaldivar stated:

FINDINGS

My own findings are as follows:

1. Summary of the History and Physical examination as listed under "Impression."
2. Abnormal chest x-ray which cannot be evaluated for pneumoconiosis because of the overlying rib masses.
3. Severe reversible airway obstruction.
4. High carboxyhemoglobin of a current smoker of a pack of cigarettes per day.
5. Air trapping by lung volumes.
6. Severe diffusion impairment.

(DX 10).

Under the "Comments" section of his report, Dr. Zaldivar noted that the CT scan results on record show no evidence of pneumoconiosis in the lungs, but that emphysema is present by CT scan. Furthermore, Dr. Zaldivar stated that, although the chest x-ray is unreadable for pneumoconiosis, the flat diaphragms shown thereon are "compatible with over-inflation of emphysema." Dr. Zaldivar also cited Claimant's congenital rib disease, and Dr. Nellhaus' note indicating that chondrosarcoma was diagnosed in 1986. Moreover, Dr. Zaldivar stated that this process is unrelated to Claimant's coal mine occupation. In summary, Dr. Zaldivar stated:

OPINIONS

Taking all of this information, my answers to your [Employer counsel's] questions are as follows:

1. There is no evidence in this case to justify a diagnosis of coal worker's pneumoconiosis nor dust disease of the lungs.

2. There is a severe pulmonary impairment present. This pulmonary impairment is the result primarily of emphysema as noted by the very low diffusing capacity measurement. There is an element of asthma as well, as demonstrated by the improvement in the FEV1 by 13% and more than 200 cc. However, the main pathology is emphysema caused by smoking. Coal worker's pneumoconiosis does not cause bullous emphysema.

3. The pulmonary impairment present that Mr. Baldwin has is disabling. Unfortunately, Mr. Baldwin has continued to smoke. Therefore, he is destroying his lung in an ongoing basis.

4. Pneumoconiosis is not the cause of his emphysema for several reasons. In the first place, pneumoconiosis does not cause reversible airway disease as demonstrated in this case. Pneumoconiosis does not cause bullous emphysema. Finally, pneumoconiosis causes a pulmonary impairment by virtue of a reaction of the lungs to inhaled dust. Such reaction is visible by CT scan or chest x-ray. In this instance, according to the CT scan of 07/02/2001, there is no evidence of any reaction of the lungs to any inhaled dust. Mr. Baldwin has been smoking for at least 30 years, if not longer. In fact, it is rare for anyone to begin smoking in their 30's. But, even if so were the case, a 30+ pack/years of smoking is sufficient to cause severe lung damage in individuals who are susceptible to the effects of tobacco smoke.

(DX 10).

Dr. Zaldivar issued a supplemental report, dated May 24, 2004, in which he sought to clarify the basis for his opinion that Claimant does not suffer from coal worker's pneumoconiosis, but rather smoking-induced emphysema (EX 6). Dr. Zaldivar stated that he did

not conclude that Claimant does not have pneumoconiosis based simply upon a negative chest x-ray. Dr. Zaldivar stated that the chest x-ray, breathing test and history are all important. Furthermore, Dr. Zaldivar stated that "the abnormalities typically found in emphysema are those of bullae, which are described in the case of Mr. Baldwin, as well as airway obstruction, which is severe but not specific for smoking nor coal worker's pneumoconiosis." However, the improvement on bronchodilators "is not the usual manifestation of coal worker's pneumoconiosis." Moreover, Dr. Zaldivar cited the hyperinflation on chest x-ray typical of a smoker. While stating that the lung parenchyma could not be evaluated on chest x-ray because of Claimant's congenital disease, Dr. Zaldivar cited the CT scan findings which reportedly did not show any inflammation of the lungs. Dr. Zaldivar noted that the patches of emphysema, without any inflammation, is typical of smoker's emphysema with lung destruction, rather than a dust-related disease, such as pneumoconiosis. Accordingly, Dr. Zaldivar reiterated that, in his opinion, Claimant "suffers from severe emphysema caused by his tobacco smoking habit and not any coal worker's pneumoconiosis." (EX 6).

In a supplemental report, dated July 7, 2004, Dr. Zaldivar reviewed additional medical data; namely, the positive findings of simple pneumoconiosis by Drs. Aycoth and Cappiello of the chest x-ray, dated January 23, 2002 (EX 9). In summary, Dr. Zaldivar stated that the readings are "incorrect." He noted that the lung parenchyma "can hardly be seen." Accordingly, Dr. Zaldivar questioned how Drs. Aycoth and Cappiello could state that pneumoconiosis affected all six zones. Therefore, he reiterated his suggestion that a CT scan is needed to evaluate the lung parenchyma. Furthermore, he reiterated his prior findings, as set forth in his previous report (EX 9).

Dr. Robert B. Altmeyer, a B-reader who is Board-certified in Internal Medicine and Pulmonary Diseases, issued a report, dated July 11, 2004, in which he reviewed the available medical data (EX 10). At the conclusion of his report, Dr. Altmeyer addressed the question posed by Employer's counsel regarding the presence of pneumoconiosis. In summary, Dr. Altmeyer stated, in pertinent part:

> After having reviewed all the records as noted above, these records persuade me, with a reasonable degree of medical certainty, that this man does not have coal workers' pneumoconiosis. Because he has expansile lesions of the ribs, apparently it has been very difficult for all the radiologists and B-readers involved to see the lungs clearly. Therefore, one must rely on CT scanning to make a diagnosis of coal workers' pneumoconiosis. Therefore, it is very unlikely, in my opinion with a reasonable degree of medical certainty, that this man has evidence of pneumoconiosis by CT scan. Additionally, he had a very significant tobacco smoking history and has changes by CT scan consistent with tobacco induced cigarette smoking. He has a severe degree of airways obstruction by pulmonary function studies. Individuals who have pneumoconiosis, which is to mild to show up by chest x-ray or CT scanning, have never been shown in the English literature, which I review, to (sic) degree of airflow obstruction. Therefore, it would be extremely unlikely for an individual to have this degree of airflow obstruction from a disease which does not show up by CT scan, as reported by very prominent radiologists skilled in the reading of CT scans at the University of Cincinnati. Therefore, this man's imaging procedures as well as his

> pulmonary function studies, particularly with acute reversibility, are not consistent with the affects of coal workers' pneumoconiosis. Individuals who have airways obstruction from coal workers' pneumoconiosis do not have acute bronchoreversibility, which has been documented to be present in this case.
>
> In summary, I believe that this man's CT scans and pulmonary function studies have not shown changes of pneumoconiosis. Therefore, I believe that it is extremely unlikely that this man has any significant coal workers' pneumoconiosis or any disease acquired from the inhalation of coal dust in coalmines. This is a very unusual case in which there are expansile rib lesions obscuring the lung parenchyma. Therefore, one must rely upon the CT scan reports. I believe that the CT scan reports of the radiologists at the University of Cincinnati are the correct ones. I believe this because of their national reputation in the diagnosis of pneumoconiosis by imaging techniques.

(EX 10, pp. 12-13).

Dr. Robert A.C. Cohen, a B-reader who is Board-certified in Internal Medicine and Pulmonary Disease, issued a report, dated July 24, 2004, in which he reviewed and analyzed the available evidence (CX 1). After summarizing the data, Dr. Cohen opined that Claimant suffers from coal worker's pneumoconiosis citing Mr. Baldwin's 34 years of coal mine employment, symptoms of chronic lung disease noted by many examiners, pulmonary function evidence of "severe obstructive lung disease with diffusion impairment," resting arterial blood gas studies which showed "significant gas exchange abnormalities," a 20-35 pack year smoking history, no other significant occupational exposures, and, mixed chest x-ray and CT scan evidence for pneumoconiosis. Furthermore, Dr. Cohen noted that, "[i]f the x-ray evidence were judged to be negative for classical pneumoconiosis it would not change my opinion that Mr. Baldwin has clinical and physiological evidence of coal worker's pneumoconiosis." (CX 1, pp. 5-6). Moreover, Dr. Cohen opined that Claimant's occupational exposure is a cause of his obstructive lung disease. In making this determination, Dr. Cohen cited the severely reduced FEV1/FVC ratio on pulmonary function testing, findings of emphysema as clearly demonstrated on chest x-rays and CT scan, and medical literature which establishes that coal dust causes obstructive lung disease. In addition, Dr. Cohen opined that, contrary to the opinion expressed by Dr. Zaldivar, emphysema, diffusion impairment, and obstruction can be caused, not only by tobacco smoke, but also coal mine dust exposure. Dr. Cohen also cited supporting medical literature. Moreover, Dr. Cohen opined that "the pathogenesis of smoking-related emphysema and dust-related emphysema is identical. Thus, there is no reason to distinguish them in any way." (CX 1, pp. 6-7). Dr. Cohen also disputed Dr. Zaldivar's assertion that asthma plays a role in Claimant's obstructive pulmonary impairment. Citing the American Thoracic Society criteria, Dr. Cohen stated that the FEV1 post-bronchodilator improvement form 1.10 liters to 1.26 liters was not significant. Moreover, Dr. Cohen noted that the "FEV1 remained severely reduced at only 35% of predicted normal." In addition, Dr. Cohen found no documentation that Claimant had episodic severe bronchospasm. Furthermore, Dr. Cohen stated that, in view of the severe abnormalities on pulmonary function testing and arterial blood gases, Claimant is disabled from even the most sedentary of labor. Therefore, Claimant is clearly incapable of performing his last usual coal mine job as a continuous miner operator, which entailed lifting heavy cable and bags of rock dust (CX 1, pp. 8-9). In conclusion, Dr. Cohen stated:

> The sum of the medical evidence in conjunction with this patient's work history indicates that Mr. Baldwin's more than 34 years of coal mine dust exposure and his 20 to 35 pack years of exposure to tobacco smoke were significantly contributory to the development of his severe obstructive lung disease, diffusion impairment, and hypoxemia on arterial blood gases. This degree of impairment is clearly disabling for the duties of his last coal mining job as a continuous miner operator.

(CX 1, p. 9).

Dr. Cohen also testified at deposition on January 14, 2005 (CX 8). In summary, Dr. Cohen reiterated that Claimant suffers from an obstructive pulmonary impairment, and that the known exposures for this disease are coal mine dust and tobacco smoke. Furthermore, Dr. Cohen stated that the patterns of impairment are the same for both exposures. Accordingly, one cannot differentiate between the causes (CX 8, p. 14). However, Dr. Cohen also explained that a person who has a susceptibility to pulmonary toxins would be susceptible to both cigarette smoking and coal mine dust (CX 8, pp. 19-20,28). Moreover, in determining the relative contribution of each of the etiologies (*i.e.,* smoking and coal mine dust), Dr. Cohen found that Claimant's exposures are very comparable (CX 8, p. 23).[3] Accordingly, Dr. Cohen concluded that Claimant's impairment is due to both his tobacco and coal mine dust exposures, citing supporting medical literature (CX 8, p. 25).

Discussion and Applicable Law

Pneumoconiosis

Section 718.202 provides four means by which pneumoconiosis may be established. Under §718.202(a)(1), a finding of pneumoconiosis may be made on the basis of the x-ray evidence. As stated above, the August 30, 2001 x-ray is inconclusive, because there is a dispute among dual-qualified B-readers and Board-certified radiologists as to whether it is even readable for pneumoconiosis. On the other hand, the January 23, 2002 films is positive for pneumoconiosis, since both dual-qualified B-readers and Board-certified radiologists found that it is readable for pneumoconiosis, and they both found evidence of simple pneumoconiosis. Therefore, taken as a whole, the preponderance of the x-ray evidence is positive for pneumoconiosis. Accordingly, I find that Claimant has met his burden of establishing the presence of pneumoconiosis under §718.202(a)(1).

Under §718.202(a)(2), a finding of pneumoconiosis may be made on the basis of biopsy or autopsy evidence. In the absence of any such evidence, this subsection is not applicable.

[3] Dr. Cohen cited a 34-year history of coal mine employment and a 20 to 35 pack year exposure to tobacco. As stated above, I find that Claimant has established a coal mine employment history of at least 25 years, and that Claimant had a 20 to 30 pack year cigarette smoking history. However, I find that the slight discrepancies in the coal mine employment and cigarette smoking histories cited by Dr. Cohen do not undermine his overall opinion. First, I note that the proportion between the two exposures is similar. Moreover, even if Claimant "only" engaged in coal mine employment for 25 years, it still constitutes a significant period of occupational dust exposure.

Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of several cited presumptions are found applicable. In the instant case, the presumption of §718.304 does not apply because there is no evidence in the record of complicated pneumoconiosis. Section 718.305 is inapplicable to claims filed after January 1, 1982. Finally, the presumption of §718.306 does not apply to living miner's claims. Therefore, the Claimant cannot establish pneumoconiosis under §718.202(a)(3).

Under §718.202(a)(4), a determination of the existence of pneumoconiosis may be made if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in §718.201. Pneumoconiosis is defined in §718.201 means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both "Clinical Pneumoconiosis" and "Legal Pneumoconiosis." *See* 20 C.F.R. §718.202(a)(1) and (2).

As outlined above, a majority of the CT scan interpretations are negative for pneumoconiosis. However, the CT scan interpretations by dual-qualified B-readers and Board-certified radiologists are conflicting regarding the presence or absence of pneumoconiosis. Accordingly, I find that the CT scan evidence neither precludes nor establishes the existence of pneumoconiosis. Moreover, even assuming that the CT scan evidence was negative for "clinical pneumoconiosis," it would not preclude a finding of "legal pneumoconiosis," as defined in §718.201(a)(2).

As stated above, in addition to the CT scan interpretations, the record includes the medical notes, reports, and/or deposition of Drs. Nellhaus (EX 11, 7), Gaziano (DX 7), Zaldivar (DX 10; EX 6, 9), Altmeyer (EX 10), and Cohen (CX 1,8), respectively.

Dr. Nelhaus cited Claimant's COPD in his medical notes without expressly stating its etiology (EX 11). In his supplemental report, Dr. Nellhaus stated that the CT scan of the chest did not show any nodularity consistent with pneumoconiosis and he concluded that there is no objective data to diagnose coal worker's pneumoconiosis. However, it appears that Dr. Nellhaus' finding is merely a determination that he found no objective evidence of *clinical* pneumoconiosis, but that he does not rule out *legal* pneumoconiosis. As stated in Dr. Nellhaus' report, in pertinent part: "While we know that coal dust exposure can contribute to COPD, it would be difficult to assess the relative contribution of cigarette smoking and coal dust to his COPD." (EX 7). This suggests that Dr. Nelhaus believes that coal dust exposure may have also played a contributing role in Claimant's COPD. Accordingly, I find that Dr. Nelhaus' report is inconclusive regarding the presence or absence of legal pneumoconiosis, and its possible contributing role in Claimant's total disability. Therefore, despite his status as Claimant's treating physician, I accord Dr. Nelhaus' opinion little weight.

Of the remaining physicians, Drs. Gaziano and Cohen found that Claimant has pneumoconiosis and chronic obstructive pulmonary disease which are attributable to coal mining and cigarette smoking. Furthermore, they found that both conditions contribute to Claimant's severe, totally disabling pulmonary impairment. On the other hand, Drs. Zaldivar and Altmeyer opined that Claimant does not have pneumoconiosis.

Although the x-ray, dated August 30, 2001, and the CT scan evidence are inconclusive, the preponderance of the chest x-ray evidence is positive for simple pneumoconiosis. Accordingly, Drs. Gaziano and Cohen are, at least, as justified to rely on such evidence to support their findings of pneumoconiosis as Drs. Zaldivar and Altmeyer are to support their findings of no pneumoconiosis. Moreover, none of the foregoing physicians relied exclusively upon x-ray evidence in reaching their conclusions. Accordingly, I find that the x-ray and CT scan evidence is not dispositive of this case.

Having carefully weighed the conflicting medical opinion evidence, I accord the most weight to Dr. Cohen's well-reasoned and documented opinion regarding the "pneumoconiosis," "causal relationship," and "causation" issues. In making this determination, I find that Dr. Cohen provided a thorough analysis of the available data, and incorporated medical literature to support his opinion that Claimant suffers from a totally disabling pulmonary impairment which is due to both his extensive coal mine employment and cigarette smoking histories. In particular, I find that Dr. Cohen's analysis of the pulmonary function results, in which he noted that the reversibility shown post-bronchodilator was relatively small, is persuasive. Although Dr. Cohen's opinion is supported by that of Dr. Gaziano, I accord less weight to Dr. Gaziano's opinion because his analysis was rather cursory. Furthermore, I accord little weight to the contrary opinions of Drs. Altmeyer and Zaldivar.

In so finding, I note that Dr. Altmeyer's opinion focuses almost exclusively upon the issue of *clinical* pneumoconiosis. Although Dr. Altmeyer briefly mentions Claimant's pulmonary function studies, his discussion of the pneumoconiosis issue is based almost entirely upon the alleged absence of pneumoconiosis on x-ray and CT scan. Moreover, Dr. Altmeyer refers to the "acute reversibility" found on pulmonary function studies. However, as stated above, I find Dr. Cohen's analysis of the pulmonary function studies to be much better reasoned and documented. As stated by Dr. Cohen, the results post-bronchodilator are qualifying and still reveal a severe pulmonary impairment. Since the "improvement" shown on pulmonary function studies was one of the primary bases for Dr. Zaldivar's finding of no pneumoconiosis, I also accord little weight to Dr. Zaldivar's opinion. In view of the foregoing, I find that Claimant has established pneumoconiosis under §718.202(a)(4).

I have also weighed all the relevant evidence together under 20 C.F.R. §718.202(a) to determine whether the miner suffered from pneumoconiosis. Since the preponderance of the overall x-ray evidence is positive for "clinical" pneumoconiosis and the more probative medical opinion evidence establishes "legal" pneumoconiosis, I find that the existence of pneumoconiosis has been established under 20 C.F.R. §718.202(a). *Penn Allegheny Coal Co. v. Williams,* 114 F. 3d 22 (3d Cir. 1997); see also *Island Creek Coal Co. v. Compton*, 211 F. 3d 203, 2000 WL 524798 (4th Cir. 2000).

Causal Relationship

Since Claimant has established the presence of pneumoconiosis, he is entitled to the rebuttable presumption that the disease arose from his more than ten years of coal mine employment. 20 C.F.R. §718.203. This presumption has not been rebutted. However, in order

to be eligible for benefits, Claimant still must establish that he suffers from a totally disabling pulmonary or respiratory impairment, and that such total disability is due to pneumoconiosis.

Total Disability

The regulations provide that a claimant can establish total disability by showing the miner has a pulmonary or respiratory impairment which, standing alone, prevents the miner from performing his or her usual coal mine work, and from engaging in gainful employment in the immediate area of his or her residence requiring the skills or abilities comparable to those of any employment in a mine or mines in which he or she previously engaged with some regularity over a substantial period of time. *See* 20 C.F.R. §718.204(b)(1). Where, as here, complicated pneumoconiosis is not established, total disability may be established by pulmonary function tests, by arterial blood gas tests, by evidence of cor pulmonale with right-sided congestive heart failure, or by physicians' reasoned medical opinions, based upon medically acceptable clinical and laboratory diagnostic techniques, that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in his usual coal mine work or comparable employment. *See* 20 C.F.R. §718.204(b)(2)(i)-(iv).

As outlined above, the pulmonary function tests and arterial blood gas studies are qualifying under the standards stated in Part 718, Appendices B and C. Therefore, Claimant has established total disability pursuant to §718.204(b)(2)(i) and §718.204(b)(2)(ii).

Since there is no evidence which establishes the presence of cor pulmonale with right-sided heart failure, Claimant cannot establish total disability pursuant §718.204(b)(2)(iii).

Under §718.204(b)(2)(iv), total disability may also be found if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner respiratory or pulmonary condition prevented the miner from engaging in his usual coal mine work or comparable and gainful work.

As summarized above, virtually all of the physicians of record who addressed the total disability issue agree that Claimant suffers from a severe pulmonary impairment, which would preclude him from performing his last usual coal mine job or comparable work. In view of the foregoing, I find that Claimant has also established total disability under §718.204(b)(2)(iv).

Having found total disability on the basis of the pulmonary function studies, arterial blood gas tests, and the medical opinion evidence, I find little, if any, contrary probative evidence. Accordingly, I find that, taken as a whole, Mr. Baldwin has clearly established total disability under §718.204(b).

Total Disability Due to Pneumoconiosis

Although Claimant has established that he suffers from pneumoconiosis arising from coal mine work, and that he is totally disabled by his pulmonary or respiratory impairment, he still has the burden of establishing that the total disability is due to pneumoconiosis. 20 C.F.R. §718.204(c).

Under the provisions of §718.204(c)(1), "a miner shall be considered totally disabled due to pneumoconiosis if pneumoconiosis, as defined in §718.201, is a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment" (*i.e.,* pneumoconiosis had a material adverse effect on the miner's respiratory or pulmonary condition; or, it materially worsened a totally disabling respiratory or pulmonary condition which was caused by a disease or exposure unrelated to coal mine employment). Furthermore, the cause or causes of the Claimant's total disability shall be established by means of a documented and reasoned physician's opinion. See 20 C.F.R. §718.204(c)(2).

For the reasons outlined above, I accord the most weight to Dr. Cohen's opinion, which is supported by that of Dr. Gaziano, over the contrary opinions of Drs. Zaldivar and Altmeyer. Accordingly, I find that the better reasoned medical opinion evidence establishes that Claimant's occupational coal dust exposure (*i.e.,* pneumoconiosis) is a substantially contributing cause of his total disability. In view of the foregoing, I find that Claimant has established total disability due to pneumoconiosis under §718.204(c).

Conclusion

Having considered all of the evidence, I find that Claimant has established the presence of simple pneumoconiosis arising from his coal mine employment; he is totally disabled as defined in the Act and regulations; and, pneumoconiosis is at least a substantial contributing cause of such total disability. Therefore, Claimant is entitled to benefits under the Act. Accordingly, Employer has failed to establish a change in conditions or a mistake in a determination of fact pursuant to §725.310.

Commencement of Entitlement to Benefits

Since the evidence does not establish the month of onset of total disability due to pneumoconiosis arising out of coal mine employment, the District Director correctly found that benefits commenced effective June 1, 2001, beginning with the month during which the miner filed his claim. 20 C.F.R. §725.503(b). (DX 2, 19, 29).

Attorney's Fees

No award of attorney's fees for services to Claimant is made herein since no application has been received. Thirty days are hereby allowed to Claimant's counsel for the submission of such application. His attention is directed to 20 C.F.R. §725.365 and §725.366 of the regulations. A service sheet showing that service has been made upon all parties, including Claimant, must accompany the application. Parties have ten days following the receipt of such application within which to file any objections. The Act prohibits the charging of a fee in the absence of an approved application.

ORDER

It is hereby ORDERED that:

1. the claim of Lorenza D. Baldwin for benefits under the Black Lung Benefits Act is hereby GRANTED;

2. the Employer's request for modification of the approved claim of Lorenza D. Baldwin is hereby DENIED;

3. Kanawha Coal Company shall pay to Lorenza D. Baldwin, all benefits to which he is entitled under the Act, commencing as of June 1, 2001.

4. Kanawha Coal Company shall reimburse the Secretary of Labor for payments made under the Act to Lorenza D. Baldwin, if any, and deduct such amount as appropriate from the sum it is ordered to pay under the preceding paragraph above.

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RICHARD A. MORGAN
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this Decision and Order, by filing a notice of appeal with the ***Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601.*** A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, Frances Perkins Building, Room B2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.